technique, the chances of permanent cure would be immensely increased and the operation could be undertaken with great probability, almost certainty, of success. But as the most important of these conditions can never be ascertained *intra vitam*, and one is thus unable to differentiate clinically between the favorable and the unfavorable cases, the author is forced to conclude that the Moore-Corradi method as at present applied, and in spite of the undoubted improvements that have been made in its technique, is a most dangerous procedure, essentially lacking in the elements of that scientific precision and knowledge of avoidable perils which are necessary to elevate it out of the plane of empiricism and surgical experimentation. Its chief recommendation now rests upon the naked fact that in three out of fifteen recorded cases (20 per cent.), it has actually arrested the progress of aneurisms and saved life. Apart from this clinical fact, it can claim but little else in its favor except that in the presence of almost certain death from the disease when allowed to follow its natural evolution, even a remote possibility of survival by operation is better than no chance at all.

The author states in conclusion that in the light of present experience we should restrict our recommendation of the combined method to that small group of comparatively favorable cases in which the aneurisms are confined to the inframesenteric portion of the aorta, and then only after other safer methods of treatment had been tried and failed. In aneurisms situated in the upper part of the aortic tract, the boundaries of which cannot be even approximately determined, the author regards this procedure in the light of a pure experiment—a veritable surgical adventure—which would be justified solely by the imminent danger of death from rapid progress of the disease which threatened rupture of the sac, and associated with great suffering. Even then the operation could not be recommended, but should be undertaken solely at the urgent solicitation of the patient after a thorough understanding that the chances would be no less than 70 per cent. against his recovery from the operation.

A Report of Twenty four Operations Performed during Spinal Analgesia.—BAINBRIDGE (*Medical News*, May 4, 1901), after reporting in detail the results of twenty-four cases, states that the following conclusions are made from fifty cases, which include those just noted: 1. Cocaine is far more satisfactory than eucaine. The latter is less potent, more evanescent, the areas of analgesia are frequently "patchy," having the pain sense retained all around them and not being so complete below definite levels. The cocaine produces no more unpleasant after-effects than eucaine, and is decidedly more reliable. 2. Analgesia to the level of the diaphragm can be depended upon in all cases where a moderate dose of a potent solution of cocaine has been introduced by lumbar puncture. In some the analgesia is sufficient for operation on the upper extremities. 3. Complete analgesia, including the eyes, mouth, and throat, has occurred. It does not entail more severe after-effects than when the lower extremities only are involved. 4. The preparation of the patient as for a general anæsthetic diminishes all the unpleasant effects of cocaine and eucaine, and often prevents them altogether. 5. By moderate doses of bromides before the injection the initial vomiting is frequently avoided and the liability of headache lessened.

6. In neurotic patients there are often hysterical symptoms directly following the completion of the injection; but, as a rule, in a few moments a calm follows and the patient lies perfectly still. 7. Initial nausea and vomiting often occur soon after the puncture, but last only for a moment or two, and usually do not recur during the operation. As consciousness, as well as the muscular power, is preserved, the danger of the introduction of the vomitus into the lungs is practically *nil*. 8. Analgesia lasts from thirty minutes to four hours. 9. Depression after the puncture is considerable. The use of ethyl chloride (Bengue) largely prevents pain when the needle is introduced. 10. The preparation of the patient, the use of nitroglycerin by hypodermic injection, or the employment of coal-tar products with caffeine, control the headache, which is in many instances an after-effect of spinal puncture. 11. In a few cases there may be motor paraplegia or vertigo. Both are temporary. 12. Spinal puncture has not affected normal or diseased kidneys. 13. Usually the tactile power, muscular sense, and the ability to detect heat and cold are retained. The cautery at a dull red heat causes no pain, while hot water produces marked discomfort. 14. Usually the patient sleeps the first night. 15. There is often a temperature of a few degrees within eight or ten hours of the operation. Whether this is the direct result of the puncture or the effect of psychic disturbances is not determined. The circulation and respiration are not seriously embarrassed.

The Diagnosis and Surgical Treatment of Renal Tuberculosis.—BROWN (*Boston Medical and Surgical Journal*, May 30, 1901) states that for obvious reasons, in this malady, no one can speak authoritatively, either as to the final results of supposed radical surgical treatment, or, on the other hand, as to the certain progress toward a fatal termination of all cases which are not treated in some way. Despite the immense amount accomplished by earnest labor in the field of tuberculosis, one must hope that something more specifically curative than the knife, sanitation, or the piney woods may soon be discovered. In other localizations of the disease the importance of early diagnosis has long been appreciated; but when the kidney is involved, recognition of the fact is apt to be unfortunately tardy. In all cases of pyelitis, nephritis, and cystitis the etiology should be determined or at least most diligently sought for. In order to secure more satisfactory results from surgical treatment, renal tuberculosis must be detected in anticipation of rather than long after the objective symptoms have become so conspicuous as not alone to render differentiation of the urine difficult, but to have involved so much of other parts of the urinary tract as to preclude a radical operation. Urinary analysis in general should mean as careful a routine search for tubercle bacilli as is customarily given to the other formed elements of a sediment. There are cases of renal tuberculosis where the lesions are not in open communication with the urinary channels, hence the microorganism is not possibly attainable for microscopical or inoculation evidence. It is not so very unusual for an open tuberculosis renal lesion to shed so few bacilli that persistent microscopical search fails to find them. Here animal inoculation should always be early resorted to. Sometimes the subjective symptoms are quite pronounced, even in the early stages of the disease; in other cases the pains are little noticed in advanced stages of the